stances; spasmodic in one. The other symptoms are noted as follows: Bronchitis in 5; emaciation 5; bruit 4; external tumour 4; dysphagia 3; dyspnœa 6; wheezing respiration 3; palpitation 3; tracheal rales 3; œdema and lividity of the face 1; displacement of the heart, tenderness of the tumour, convulsions, aphonia, and anæmia, each 1. After the bruit and the appearance of a tumour externally, the symptoms of interference with the respiratory organs seem to be the most uniformly characteristic. The wheezing respiration especially, was uniformly associated with pressure upon the trachea, or one of the large bronchi. In one case it was the diagnostic symptom. But in the aneurisms of the descending aorta, these symptoms were wanting, excepting in one case. A bruit is mentioned in but four cases, although it was carefully looked for in others.

The termination by rupture seemed to be most uniform in the descending aorta, while those in the arch generally terminated by exhaustion, or some accompanying disease.

QUINCY, ILL., Oct. 15th, 1859.

ART. VIII.—*Case of Compound Comminuted Fracture of the Patella.* By J. LEVERGOOD, M. D., Lancaster, Pa.

ON the nineteenth day of February, 1859, a young man, named Patrick McKeefer, aged about thirty-five years, was admitted into the Lancaster County Hospital under the following circumstances:—

About eight or ten weeks previous to his admission, while engaged in driving a stage, he was kicked by one of his horses on the left patella, producing a compound comminuted fracture of that bone. At the time of the accident, and for some time subsequently, the hemorrhage from the wound was profuse. He was brought to this city and placed in charge of a physician, but after being under treatment about four weeks, he very imprudently left his bed without the knowledge or consent of his professional attendant, and attempted, with the assistance of a crutch, to walk upon his limb. The result of his temerity, of course, was disastrous; the imperfectly united fragments were again widely separated, and the joint became stiff, swollen, and excessively painful. He was again placed under treatment, but circumstances occurred rendering his removal to the hospital necessary.

On his admission I found the knee stiff, very slightly flexed, exceedingly sensitive upon the least motion, and so much distended by an accumulation of fluid as to make it almost impossible to distinguish the number and situation of the fractured portions of the rotula. The slightest palpation of the tumefied mass afforded to the hand, very perceptibly, the sense of fluctuation, and the most prominent part of the swelling was on the anterior part of the joint. His general health was excellent.

Although almost every expedient had been exhausted, previously to his entrance into the hospital, with the view of securing the absorption of the fluid contained in the joint, and a reunion of the fractured bone, it was deemed advisable, after consultation with my colleagues, to make another attempt to preserve the patient's limb. I therefore gave him alterative doses of calomel and opium, applied tincture of iodine, and carefully bandaged the leg and laid it in a splint. This course of treatment was sedulously persevered in for about one week, but there appearing to be no visible improvement, and as the fluid was beginning to burrow under the extensor muscles of the thigh, I at once made an incision into the joint and evacuated about twelve ounces of pus.

Feb. 28th. Has not rested well; no appetite; and the accumulation of fluid is nearly as great as before the joint had been opened. Made another incision on the side opposite to the first one, and removed ten ounces of purulent matter. As the matter had invaded the interstices of the muscles of the thigh, there was considerable handling and compression necessary in order to dislodge it from the sinuses in which it was deposited. Ordered tonics, generous diet, and porter daily.

March 4th. A profuse sanious and unhealthy discharge going on from both incisions; and the synovial fluid is, and has been for some time, escaping. Notwithstanding, the patient's health remains unimpaired, his appetite is good, and his sleep is tolerably refreshing. At this stage of the case I suggested the propriety of amputating the leg, keeping in mind the great length of time since the injury was received—the exhausting effect of the profuse and unhealthy discharge then going on—the many futile efforts, thus far, made to restore the limb to usefulness—and recollecting that South, in his translation of Chelius, tells us that "compound fracture of the knee-cap *almost invariably* requires amputation, as the injury producing it is so severe that there can be little expectation of a satisfactory issue," I considered this a case requiring and justifying the use of the knife. But the patient not being willing to submit to this supposed *dernier ressort*, I continued the treatment as heretofore, and at the expiration of my term of hospital duty (first of May), I had the unfeigned pleasure of seeing my patient discharged well, with no other inconvenience than that of a slightly anchylosed knee. He walks without a staff, is engaged again in driving stage, and says his leg is "nearly as good as ever."

The above is a condensed account of this case as detailed in a paper read before the Lancaster City Medical Society, and it furnishes us with another proof of the propriety, when there is a preternatural accumulation of fluid in the knee-joint, of making an incision and evacuating it. In the August number of the *Lancet*, there are recorded three or four cases illustrating the feasibility of this procedure, and some of the cases, in many respects, are very analogous to the one above related.